North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
and Substance Abuse Services

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Richard J. Visingardi, Ph.D., Director

October 20, 2003

MEMORANDUM

TO: Area Program Directors

FROM: Stanley A. Slawinski, Ph.D., Chief
State Operated Services

RE: Mental Health Community Capacity Expansion
and Olmstead Discharges

This memo provides a review of the activities the Division has initiated with area program/LMEs to expand community based mental health services and to serve individuals who are discharged from hospital units that are being downsized (Olmstead discharges) as well as those who would have used the beds if community services had not been in place. The information contained in this memo has been shared with area program/LMEs in previous memos, at regional meetings and through other means, however a comprehensive overview of the process may be useful.

Community Capacity Expansion

To facilitate the expansion of community-based services for adults with mental illness, the Division is coordinating a regional planning process, typically involving the Adult Mental Health Coordinator from each area program/LME. The planning effort has dual purposes of (1) identifying and developing the array of services that people currently in State hospital beds identified for closure need in order to live in the community and (2) developing or expanding capacity to serve those who otherwise would be admitted to those state psychiatric beds. Based on this information, each area program/LME submits a plan to the Division identifying those services and resources to be developed or expanded to meet the unique needs of its community. One-time bridge funding from the Mental Health Trust Fund provides start up funding for the services and supports. The on-going cost of the

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services and supports are funded largely through the transfer of monies from the hospital to the community as the units are downsized.

Funds were first allocated for community capacity expansion in March 2002, when the Division allocated a total of $671,000 in one-time bridge funding from the Mental Health Trust Fund to the eight area programs in the South Central Region. The total allocation was annualized up to $1.8 million for FY 03 supported largely through the reallocation of moneys previously used to fund a unit closed at Dix Hospital. The allocated funds were used by the area programs to establish or expand a variety of services such as Assertive Community Treatment Teams, expanded psychosocial rehabilitation, case management, transportation, and supported housing.

Funds were allocated to area programs across the state beginning in January 2003 to expand community capacity for individuals discharged by the end of FY03 and others who would have needed the hospital beds if community services had not been in place. Over $3.8 million in one-time bridge funding, annualized up to $7.6 million in FY04 was allocated for the development and expansion of community services.

The community capacity expansion planning process has begun for one time bridge funding to be allocated in FY04. It is expected that area programs/LMEs will submit plans by mid-November and allocations will be made beginning in December 2003.

Joint Discharge Planning and Division Review

The Division has established the expectation that the area program/LME, through a case manager, hospital liaison or other staff, will be actively involved in discharge planning for each individual from their area who is being discharged from a unit being downsized. By taking a more assertive role in the discharge planning process, the area program/LME provides expertise on community services available to support the individual. Additionally, by earlier involvement in discharge planning, the area program/LME can ensure that needed community services have not only been identified, but that the individual receives the service immediately upon discharge.

Although the goal is for individuals to return to their home community, the Division recognizes that some individuals may be discharged to areas other than their home community. Such discharges would generally be the result of individual preference rather than lack of available services in the home community. In these instances, both the home area program/LME and the area program/LME to which the individual will be discharged would participate in the discharge planning, with the area program/LME to which the individual is moving taking the lead in arranging services.

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The type of setting in which the individual will live upon discharge is a critical component of the discharge plan. The Division wants to ensure that placements are appropriate, based on each individual's needs and preferences. Area program/LME and hospital staffs are encouraged to consider supported housing with services such as ACTT when preferred by the individual. Placement in congregate living settings such as group homes and family care homes should also be made when the individual has expressed an informed preference for the facility. See attached for Criteria for Congregate Living.

To ensure that community treatment, services and supports are adequate and appropriate for individuals discharged from units being downsized at state hospitals, State Operated Services staff reviews each discharge plan. The discharge plans, which are submitted by hospital staff, document the joint planning efforts of the individual, hospital and area program/LME staff. If the services, including residential placement, are adequate and appropriate for the individual and are available to the individual immediately upon discharge, the plan is approved.

Monitoring of Discharges

The Division is committed to monitoring the community tenure of individuals discharged from State hospitals through the downsizing/Olmstead process. To accomplish this, three monitoring mechanisms have been developed:

1. On-site Monitoring Visits. SOS staff make periodic visits to area program/LMEs to monitor the progress of discharged individuals. Updates are obtained from clinicians serving each individual and SOS staff meet face to face with selected individuals.

2. Services Review. At the time of discharge from the hospital, area program/LMEs enroll individuals in the Olmstead target population (AMOLM). Enrollment in this target population, which is for tracking purposes only, allows the area program/LME and the Division to monitor the types and frequency of billable services each individual receives.

3. Consumer Outcomes. The area program/LME will monitor consumer outcomes after discharge according to the following schedule: monthly for the first 6 months post-discharge, quarterly for the next 3 quarters and annually thereafter. Currently, the data is being collected using a paper tool. A secure web-based outcomes program is under development and the collected data will be submitted via the web-based program. Outcomes monitored include placement type and tenure, employment and related activities, hospitalization and crisis visits, and involvement with the criminal justice system.

To ensure a consistent list of individuals discharged under the downsizing/Olmstead process, State Operated Services sends a monthly list to the Adult Mental Health Coordinator in each

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area program/LME. It is the individuals on this list that the Division will monitor progress in the community.

If you have any questions or comments, please feel free to contact Laura White (laura.white@ncmail.net) or Jim Osberg (james.osberg@ncmail.net) at (919) 733-3654.

I greatly appreciate your involvement in this process thus far and look forward to continuing working with you. The work each of you has accomplished in this effort positively impacts the lives of those we serve.

SAS/lw

attachment

cc: Secretary Carmen Hooker Odom
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